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## Attracting and retaining GPs:

a stakeholder survey of priorities

### Abstract

#### Background

Despite being a key player in the healthcare system, training and practising general practice has become less attractive in many countries and is in need of reform.

#### Aim

To identify political priorities for improving GPs' attraction to the profession and their retention within it.

#### Design and setting

Stakeholder face-to-face survey in Belgium, 2008.

#### Method

A total of 102 key stakeholders were recruited from policymakers, professional groups, academia, GP leaders, and the media. All interviewees were asked to score 23 policies on four criteria: effectiveness in attracting and retaining GPs, cost to society, acceptance by other health professionals, and accessibility of care. An overall performance score was computed (from -3 to +3) for each type of policy — training, financing, work-life balance, practice organisation, and governance — and for innovative versus conservative policies.

#### Results

Practice organisation policies and training policies received the highest scores (mean score  $\geq 1.11$ ). Financing policies, governance, and work-life balance policies scored poorly (mean score  $\leq 0.65$ ) because they had negative effects, particularly in relation to cost, acceptance, and accessibility of care. Stakeholders were keen on moving GPs towards team work, improving their role as care coordinator, and helping them to offload administrative tasks (score  $\geq 1.4$ ). They also favoured moves to increase the early and integrated exposure of all medical students to general practice. Overall, conservative policies were better scored than innovative ones (beta = -0.16, 95% confidence interval = -0.28 to -0.03).

#### Conclusion

The reforming of general practice is made difficult by the small-step approach, as well as the importance of decision criteria related to cost, acceptance, and access.

#### Keywords

attraction-retention; primary care; public policy.

### INTRODUCTION

In most European countries, GPs and their auxiliary personnel account for the majority of patient contacts.<sup>1,2</sup> Over the last decade, the percentage of young medical graduates entering general practice has steadily declined in several Western countries.<sup>3,4</sup> At the same time, a significant proportion of qualified GPs are considering leaving medical practice;<sup>5</sup> in the UK, for example, about half of GPs leave the profession before the age of 55 years.<sup>6</sup> Many European countries face an ageing workforce and declining numbers of GPs<sup>7</sup> — as such, the profession, and therefore also primary care, is said to be in crisis and in need of reinvention.<sup>8</sup>

To explain this crisis, a complex mix of factors related to training, payment schemes, practice organisation, and work-life balance has been identified:<sup>9</sup>

- Medical schools play a key role in attracting students to become GPs; academic culture, the importance of general practice in the medical faculty, curriculum, exposure to general practice, and role models all influence the decision to take up a career in general practice.<sup>10</sup>
- The remuneration and mechanism of payment for GPs do not compare well with those for other medical specialties.

The median income of specialists was almost twice that of GPs and this gap has been widening and the dominance of the fee-for-service payment has been questioned.<sup>11,12</sup>

- In some member countries of the Organisation for Economic Co-operation and Development (OECD), GPs still work in suboptimal conditions. Examples of this include working in solo practice,<sup>1</sup> or with limited and inconsistent use of information, technology, and multidisciplinary teams.<sup>13</sup>
- General practice is facing a changing trade-off between work and private-life concerns. GPs, like other physicians, place an increasing value on time devoted to the family.<sup>14</sup> Work time and schedules are, therefore, one of the main reasons why GPs leave medicine and call for solutions that improve the work-life balance.<sup>15</sup>

Primary health care can help key decision makers to make health systems more sustainable, more cost efficient, and more equitable.<sup>16,17</sup> As healthcare spending is rising faster than economic growth in many OECD countries, priority setting at the highest level becomes necessary.<sup>16</sup> Across all countries, a complex mix of stakeholder

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## How this fits in

Primary health care cannot be conceptualised without general practice. However, in many Western countries training and practising in general practice has become less attractive compared to speciality medicine, as such, attracting and retaining GPs in the profession requires organisational and educational policies. Funding policies and those relating to work-life balance are not supported by key stakeholders, who often prefer conservative policies to innovative ones. Radical policies are needed to attract and retain GPs but they are not favoured by the stakeholders.

influences can be observed in which governments, regional authorities, politicians, professional bodies, advisory bodies, health insurers, and, in some countries, sickness funds and patient organisations play their role. In the UK, agreement on the political agenda among stakeholders has been crucial in the introduction of major healthcare reforms such as the Quality and Outcomes Framework. For sustainability of these reforms, political support is also fundamental.

Given the time needed for GP training (9 years on average in Europe), structural reforms relating to increasing the numbers of GPs is urgent. However, successful transition from proposed solutions to health policies depends on the stakes, actors involved, and the political context.<sup>18</sup> It would seem that possible solutions to the problems being faced do not translate easily into structural reforms, resulting in a *laissez-faire* attitude.<sup>19</sup>

This article aims to study the political support for solutions improving general practice attraction and retention in one country in Europe; in doing so it asks what solutions are likely to become political priorities for improving doctors' attraction to, and retention in, general practice. Key stakeholders scored a set of policies and their preferences for those that were conservative or innovative were assessed. In doing so, this study tried to understand why reforming general practice is so challenging.

## Setting

Belgium has compulsory health insurance covering the entire population and a very broad benefits package covering 77% of all healthcare expenditures. It has a high

medical density (four physicians per 1000 inhabitants) and high per capital healthcare expenditure (10.6% of the GDP). Most GPs work in solo practice with a predominantly, fee-for-service payment and no auxiliary workers. Compared with the UK, the Netherlands and countries in Scandinavia, Belgium has no gatekeeping function, more GPs per inhabitant, less-developed IT systems, and strongly competing professional bodies. The health system resembles many parts of the French system in these respects.

## METHOD

### The sample

In 2008 a stakeholder survey was carried out in Belgium. This was a tool for generating knowledge from actors and understanding their intentions, interests, and interrelations.<sup>20</sup> According to the literature, stakeholders are classified as policymakers, professional groups, academics, media, and GP leaders.<sup>21</sup>

A panel of researchers and leaders in general practice drew up an initial list of 155 names of the most influential persons in each group, such as senior administration officers, ministerial advisers, union leaders, faculty deans, senior sickness-fund administrators, editors, journalists, and students' representatives — that is, all those with major responsibilities in, or influence on, the Belgian healthcare system or the training of GPs. The extent of each individual's influence was rated by seven external leaders from different professional and public health organisations. Those who received at least three votes out of seven were retained for the survey.

In order not to leave out an important group, several validation meetings took place among the researchers. The sample was complemented by snowball sampling: each interviewee was asked to name up to three important persons in each stakeholder group. The most-cited persons were then also contacted.

In total, 116 stakeholders were contacted and 102 (88%) agreed to participate. A breakdown of the sample is given in Table 1.

### Design and measurements

For the questionnaire<sup>22</sup> the study used the multicriteria analysis approach (MCA), which is designed to assess decision making between different policies, based on several criteria. MCA has recently been used in the health sector for assessing obesity prevention<sup>23,24</sup> and health technologies in primary care.<sup>25</sup> It involves four steps:

**Table 1. Number of interviews by sociodemographic characteristics (n = 102)**

Characteristic	Interviews (n)
<b>Group</b>	
Policymakers	28
Professional groups	20
Academics	16
Media	7
GP leaders	31
<b>Language</b>	
Dutch-speaking	54
French-speaking	48
<b>Age groups (years)</b>	
20–30	3
31–40	6
41–50	30
51–60	53
≥61	10
<b>Sex</b>	
Men	75
Women	27

- identifying various policy options to solve a problem;
- identifying criteria to appraise those policies;
- allocating a score to each policy option on each criterion; and
- weighting each criterion to reflect its relative contribution to overall decision making.

In the research, an initial list of possible policies was collected from an extended literature review, as well as from recent policy initiatives in Europe.<sup>1,26</sup> The list was discussed with the research team, adapted, then piloted with experts in the medical field. No policy was excluded because of being supposedly controversial.

The study ended up with 23 policies, classified into five groups: training, financing, work–life balance, governance, and practice organisation (Table 2). In addition, each policy was classified as either conservative or innovative by the panel of researchers. The policy was considered to be conservative if it was related to already-existing solutions (such as increasing fees) and innovative if it required either a change in existing regulations (such as targeted payment) or the setting up of a new executive body. A Delphi process was carried out, with the panel of researchers classifying each policy into these two categories.

The criteria were defined according to the literature on healthcare prioritisation and

were then discussed and adapted by the panel. Four criteria were retained:

- effectiveness in improving the attraction and retention of GPs;
- cost to society;
- acceptance by other health professionals; and
- accessibility of care and patients' freedom of choice.<sup>27,28</sup>

#### Data collection

Stakeholders were interviewed in a face-to-face computer-assisted interview, conducted by a trained interviewer. During the interview the stakeholders were asked to score each policy according to each criterion on a seven-point Likert scale ranging from very negative (–3) to very positive (+3). Each criterion score was weighted to reflect its relative importance. For each interviewee, the weights were obtained during the interview, using the swing-weight method. Weights were then normalised to compute an overall score for each policy.<sup>23</sup> For each interviewee, the overall score of policy *P* equals:

$$\text{Overall Score}_P = \sum_{i=1}^4 \text{Std Weight}_i * \text{Score Criterion}_{P,i}$$

Each stakeholder could also make open-ended suggestions or comments on the policies; this helped to clarify their choices. After the interview, the interviewer rated the interview process. In total, 87% (*n* = 89) of the stakeholders had a good level of interest in the subject and 83% (*n* = 85) understood the questions well. Stakeholders also were requested to choose their first, second, and third most-favoured policies for each policy group.

#### Analysis

The difficulty of reforming primary care may be due to the complexity of the issue itself, the political context that makes new policies more or less likely to be adopted, and the political divide between powerful groups.<sup>18</sup> Accordingly, the study analysed the policy score in three steps.

First, the study compared the scores according to two policy characteristics: policy group of the interviewee (training, finance, work–life balance, practice organisation, and governance) and whether the policy was innovative or conservative in the Belgian context. As each interviewee rated 23 policies, the study used a regression model including a random component to take account of clustering at the stakeholder level. Second, to

**Table 2. Policy labels and classification**

Policy	Group	Innovative/ conservative
Selecting students of medicine by taking into account their social and communication skills, as well as their knowledge of the exact sciences	Training	Conservative
Developing a clinical activity linked with the academic centres of general practice	Training	Conservative
Better integrating general practice courses and specialty courses	Training	Conservative
Organising compulsory clerkship in general practice for all medical students	Training	Innovative
Increasing the consultation fees of general practice	Financing	Conservative
Paying GPs with a combination of capitation per patient and fee for service	Financing	Conservative
Paying GPs with a combination of wage and fee for service	Financing	Innovative
Rewarding GPs with target payment for the realisation of objectives	Financing	Innovative
Moving towards a more equitable geographical distribution, by improving the incentives to practice in low medical-density areas (LDAs)	Financing	Conservative
Allowing an evolving career, combining ambulatory curative medicine and other activities (for example, research, teaching, training)	Work-life balance	Innovative
Not penalising the work of GPs working part time	Work-life balance	Innovative
Organising local groups of professional GPs responsible for on-call duty (locum relief)	Work-life balance	Innovative
Paying GPs for their continuous training activities	Work-life balance	Innovative
Removing the individual on-call duty and replacing it with a professional service, such as 'SOS médecins'	Work-life balance	Innovative
Removing the legal quota on the number of medical students to be trained	Governance	Innovative
Supporting the creation of local resource agencies promoting the attraction and retention of GPs according to local needs	Governance	Innovative
Creating a master degree in advanced nursing practice, to back up GPs	Governance	Innovative
Financially discouraging excessive or premature recourse to second-line services (soft gatekeeping)	Governance	Innovative
Encouraging the delegation of some clinical tasks to other existing health professions (for example, nurses)	Practice organisation	Innovative
Encouraging the delegation of administrative work to administrative staff	Practice organisation	Conservative
Encouraging GPs to share a common infrastructure or a common secretariat	Practice organisation	Conservative
Encouraging GPs to work together (group practice)	Practice organisation	Conservative
Reinforcing the role of GPs in the multidisciplinary team	Practice organisation	Conservative

understand why some policies received a higher score than others, the study broke down the policy score by the contribution of each criterion (standardised weight; \* score criterion i).

Finally, the study compared each policy scores separately between stakeholder groups.

## RESULTS

The highest scores went to practice organisation and training policies (mean score = 1.40 and 1.11 respectively, [Table 3]). The lowest score went to work-life balance policies. Innovative policies scored lower (0.62) than conservative policies (1.14). When combining both covariates in a multivariate analysis, innovative policies scored lower (beta = -0.16, 95% confidence interval [CI] = -0.28 to -0.03) than their conservative counterparts (results not shown).

Individual policies' scores varied from a high positive value to a low negative value (Figure 1). The highest scores went to six policies addressing either practice organisation or the training of GPs: encouraging group practices, reinforcing the GP's role in the multidisciplinary team, integration of general practice teaching and specialty courses, compulsory clerkship in general practice for all medical trainees, encouraging GPs to share a common infrastructure, and delegation of administrative tasks. The top six policies did not include any financing, work-life balance, or governance policies.

Some groups of policy received poor scores because of their unequal performance on the four criteria. Indeed, financing and work-life balance policies were perceived as being as effective for improving GP attraction and retention as

**Table 3. Policy score analysis by policy characteristics (mean score and 95% CI from a random regression model)**

Covariate	Mean score	
	(-3 to +3)	95% CI
Group of policies		
Practice organisation	1.40	1.28 to 1.52
Training	1.11	0.99 to 1.24
Financing	0.65	0.53 to 0.77
Work-life balance	0.38	0.26 to 0.50
Governance	0.56	0.43 to 0.68
Path dependency		
Conservative policies	1.14	1.04 to 1.24
Innovative policies	0.62	0.53 to 0.71

training or practice organisation policies, but scored lower on the two other criteria: acceptability by other health professionals and cost to society (Figure 2). Work-life balance policies (for example, suppressing on-call duty) had the additional drawback of jeopardising access to primary health care.

Finally, the study analysed differences in policy scores between categories of stakeholders (policymakers, professional groups, media, academics, leaders in general practice). For each of the five groups of policies, there were no statistically significant differences in policy scoring between the stakeholder categories (all  $F$

values  $<1.7$ ;  $P>0.15$ ). When assessing each policy individually, there were no statistically significant differences between stakeholder categories for all policies apart from one: general practice leaders (but not medical unions) gave lower scores than policymakers to the delegation of clinical tasks (beta =  $-0.98$ ,  $P=0.002$ ).

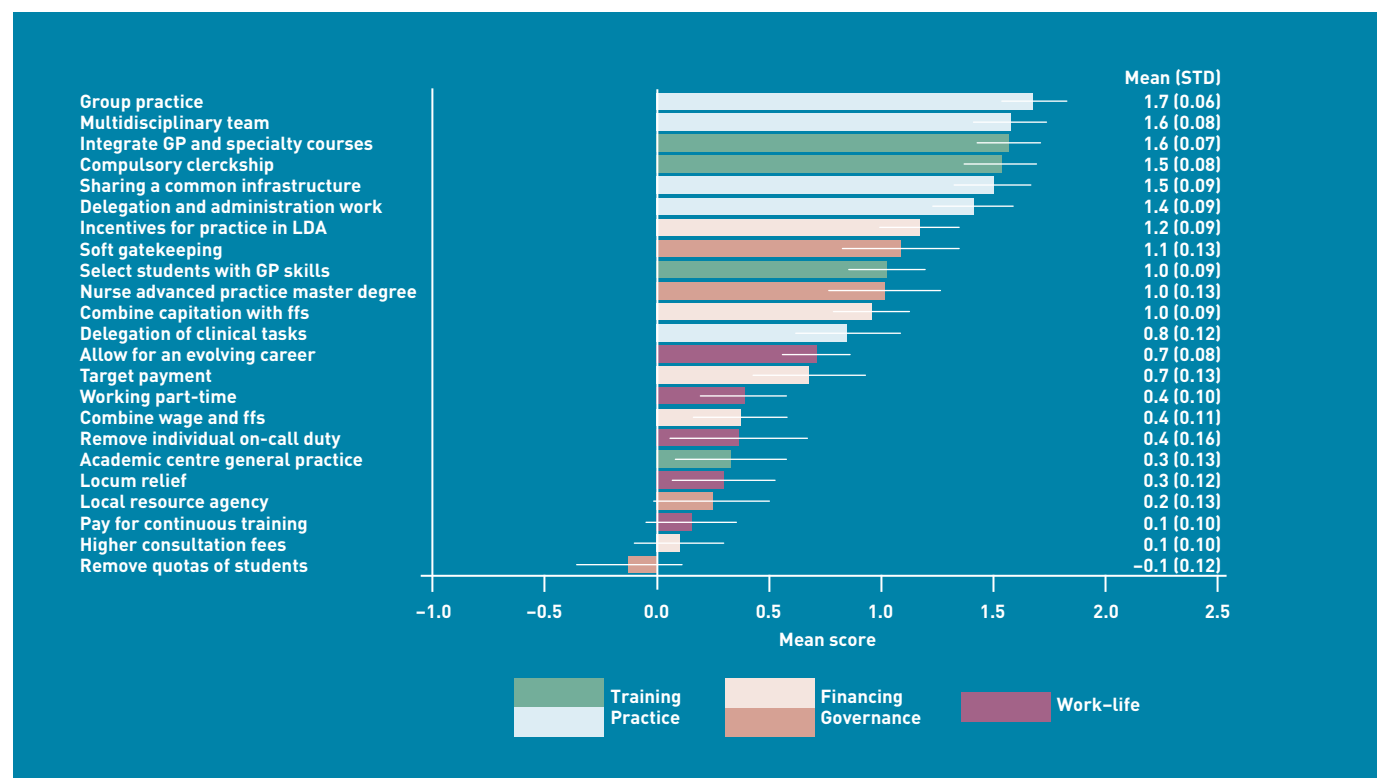
## DISCUSSION

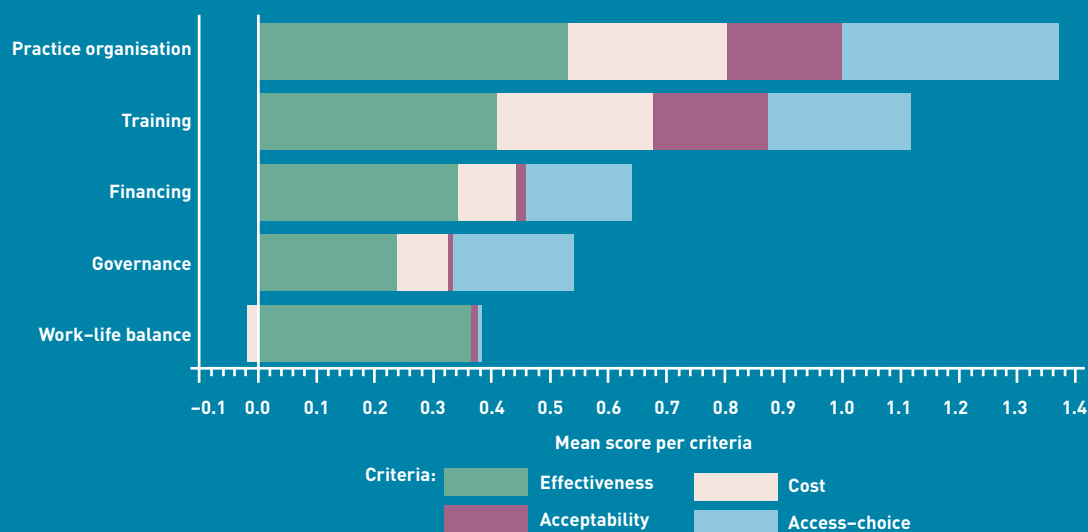
### Summary

Overall, the stakeholders were keen on moving the GPs towards group practice, improving their role in the multidisciplinary team, helping them to offload administrative tasks, having compulsory clerkship and sharing a common infrastructure. They were also keen on improving the early and integrated exposure of all medical students to general practice. However, three elements show that reforming general practice is problematic:

- Two groups of policies (financing and work-life balance) were not strongly supported by the stakeholders, although these are currently supported by the research and among the main claims of the GPs' unions;
- Some policies failed to win acceptance, not because of their lack of effectiveness, but because of their poor performance regarding cost to society, acceptance, and

**Figure 1. Policy scoring, mean value, and standard deviation per group of policy.**





Elite stakeholder survey, Belgium 2008.

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#### Ethics committee

This research did not require ethical approval.

#### Provenance

Freely submitted; externally peer reviewed.

#### Competing interests

Christiane Duchesnes, Jo Goedhuys, and Roy Remmen are on the payroll of academic departments of general practice. All other authors have declared no competing interests.

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accessibility to care.

- Innovative policies scored poorly when compared with conservative policies.

In several European countries, GPs have long been calling for improved financial conditions as well as an improved work-life balance, and research evidence strongly supports changing the payment mechanisms applied to general practice.<sup>29</sup> However, these two groups of policies received low scores. Stakeholders were not keen on them and were more willing to use training and organisational policies. For some policies, therefore, there is a mismatch between what GPs are looking for and the support of stakeholders. According to the study's findings, this mismatch appears to occur because stakeholders take a multidimensional perspective on policy making. In particular, their reluctance to use financing policies as leverage to improve GPs' attraction and retention is due to their concern to not alienate other actors, such as other health professionals. As priority-setting research has made clear, criteria such as acceptability and equity, as well as other institutional constraints, are also taken into account in decision making.<sup>30</sup>

Innovative policies received lower scores than their conservative counterparts. This is consistent with the theory of path dependency, according to which, choices that have been made in the past

systematically constrain the choices that are available in the future — a mechanism clearly at work in cost-containment policies.<sup>31</sup> Path dependency is partly due to the current institutional arrangements for decision making in health care in Belgium; decisions are made in bodies organised along professional lines (medical doctors, hospitals, home care, nurses, and physiotherapists) which impedes the emergence of a strong primary care political community in which GPs, nurses, and other primary care providers can draw up and advocate a strong primary care agenda.<sup>32</sup>

Finally, both groups of GPs (the leaders and those from the medical unions) were as divided as the other groups on all policies, including innovative ones, such as the creation of a nurse assistant master's degree, gatekeeping, and clinical delegation. These professional groups could not come up with a clear-cut programme on which they agreed. This lack of mobilisation also explains the difficulty in coming up with bold reforms of primary health care in pro-coordination policies or cost-containment policies.<sup>33</sup> The emergence of a strong policy network related to primary care is less likely if the profession is divided. The lack of a strong corporate interest weakens mobilisation and means there is no strong political partner to negotiate and implement reforms; as such, a weak GP profession also weakens public health stewardship.<sup>34</sup>

### Strengths and limitations

To the authors' knowledge, this study is the first stakeholder survey to use a multidimensional evaluation of a set of policies aimed at attracting and retaining practitioners into the profession, and it helps to distinguish three obstacles to making general practice more attractive. However, two possible risks of this study's approach are that the criteria do not correspond to the responders' own values or that the responders prefer a policy for which they have a preference independent of the criteria. In spite of this, such biases were not observed; indeed, only a minority of the responders (6%) gave a zero weighting to any criterion (acceptance by other health professionals). Moreover, average inter-criteria correlation was rather low (0.34) and only four stakeholders displayed a clear tendency to rate all criteria in the same way. It was also found that in most cases (96%), the policies with the highest score were also likely to be selected as first-, second-, or third-best policy, suggesting a strong agreement between scoring and choosing.

The study was carried out in a specific continental European setting and, as such, the priorities may be more relevant to a conservative social insurance health system and to similar primary care systems, such as those of France and Germany than systems with a national health service.<sup>35</sup> Nevertheless, the study helps to understand why reforming primary care has been a difficult task until now in many countries.

### Comparison with existing literature

In Europe, studies have shown that reforms of the primary care sector have occurred for one of the following three reasons:

- to increase the power of primary care as a purchaser of services, coordinator, and

gatekeeper;

- to broaden the service portfolio of primary care; and
- to provide supportive conditions in order to promote a stronger role for primary care.<sup>35</sup>

This work suggests that stakeholders support the third reason — the least-radical reform — while the degree of support for the second is unclear: on one hand the multidisciplinary team received a high score but, on the other, the policies related to the delegation of clinical tasks or nurse-assistant practitioners did not score well. This ambiguity is not unique and parallels the difficulties countries like France and Germany have faced in enhancing the role of primary care as coordinator of care.<sup>36</sup>

### Implications for practice and research

Although the 'disappearing GP' may jeopardise the healthcare system, this stakeholders' survey showed that the policies favoured by the stakeholders do not indicate an emerging consensus on radical change of the present situation. Changing the profession internally is on the agenda. As practices will serve more patients in the future, among the actions that can be performed within the profession are practice rearrangements like working in larger teams, adjusting GPs' task profiles, and introducing transfer of tasks to the most appropriate echelons of care.

Countries with strong general practice systems have already introduced large numbers of auxiliary personnel in primary health care. In the laissez-faire approach observed in the key stakeholders of health care, a stronger political primary care community, with prominent GP leaders showing the efficiency of general practice, would help to promote more radical alternatives.



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